		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040709

Facility Name: Alden Lincoln Rehab & H C Ctr

Address: 504 W. Wellington Ave. (Number) Chicago (City) 60657 (Zip Code)

County: Cook

Telephone Number: (773) 281-6200 **Fax #** (773) 281-6745

IDPA ID Number: 36-4003483

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven M. Kroll
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,263	5,057	5,072	17,392	8
9	SNF/PED					9
10	ICF	9,251	4,668	95	14,014	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,514	9,725	5,167	31,406	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.38%

D. How many bed-hold days during this year were paid by Public Aid?
191 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 5,123

Medicare Intermediary AdminiStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,271	22,974		222,245	175	222,420		222,420			1
2	Food Purchase		228,678		228,678	(24,723)	203,955	(10,283)	193,672			2
3	Housekeeping	82,033	15,685		97,718	70	97,788		97,788			3
4	Laundry	63,601	10,323		73,924	76	74,000		74,000			4
5	Heat and Other Utilities			71,472	71,472		71,472		71,472			5
6	Maintenance	47,414		108,597	156,011	3,134	159,145	3,666	162,811			6
7	Other (specify):*											7
8	**TOTAL General Services**	392,319	277,660	180,069	850,048	(21,268)	828,780	(6,617)	822,163			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,173,399	53,543	2,537	1,229,479	1,949	1,231,428	(312)	1,231,116			10
10a	Therapy											10a
11	Activities	59,072	1,026	2,215	62,313	54	62,367		62,367			11
12	Social Services	34,784		412	35,196		35,196		35,196			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,267,255	54,569	9,964	1,331,788	2,003	1,333,791	(312)	1,333,479			16
	C. General Administration											
17	Administrative	75,878			75,878		75,878		75,878			17
18	Directors Fees											18
19	Professional Services			445,077	445,077		445,077	(394,995)	50,082			19
20	Dues, Fees, Subscriptions & Promotions			30,604	30,604	(3,074)	27,530	(24,526)	3,004			20
21	Clerical & General Office Expenses	375,561	19,998	12,617	408,176	70	408,246	47,118	455,364			21
22	Employee Benefits & Payroll Taxes			252,677	252,677	22,269	274,946	36,147	311,093			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,399	1,399		1,399	8,320	9,719			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,320	32,320		32,320	88	32,408			26
27	Other (specify):*											27
28	**TOTAL General Administration**	451,439	19,998	774,694	1,246,131	19,265	1,265,396	(327,848)	937,548			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,111,013	352,227	964,727	3,427,967		3,427,967	(334,777)	3,093,190			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr #0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,724	27,724		27,724	15,315	43,039			30
31	Amortization of Pre-Op. & Org.							2,973	2,973			31
32	Interest			48,607	48,607		48,607	7,364	55,971			32
33	Real Estate Taxes			160,038	160,038		160,038	3,607	163,645			33
34	Rent-Facility & Grounds			703,728	703,728		703,728	24,520	728,248			34
35	Rent-Equipment & Vehicles			8,349	8,349		8,349	11,406	19,755			35
36	Other (specify):*											36
37	**TOTAL Ownership**			948,446	948,446		948,446	65,185	1,013,631			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,773	569,352	794,125		794,125	(328,976)	465,149			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		224,773	622,056	846,829		846,829	(328,976)	517,853			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,111,013	577,000	2,535,229	5,223,242		5,223,242	(598,568)	4,624,674			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,000)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(461)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,697)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,424)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,593)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(455,458)	VARY	34
35	Other- Attach Schedule **SEE PG 5A**	(117,517)	VARY	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (572,975)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (598,568)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Lincoln Rehab & H C Ctr

ID# 00-40709

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-costs for part b therapy c/a in 5212/3/4	$ (25,353)	39	1
2	non-costs for hmo therapy c/a in 5040	(89,135)	39	2
3	non-costs for hmo drugs c/a in 5042	(16,955)	39	3
4	non-costs for hmo nursing supp.c/a in 5026	(6,848)	39	4
5	non-costs for oxygen c/a in 5080	(574)	39	5
6	PAC FEE	(1,202)	20	6
7	community relation (non allowable expense)	(526)	20	7
8	reclass painting>$1,500 for 2000 from ln 6 to pg 20	(6,413)	6	8
9	record deprec exp on painting reclassed for 2000	1,069	6	9
10	record deprec exp on painting reclassed for 1999	3,900	6	10
11	adj rent to equal actual for year 2000	24,520	34	11
12				12
13				13
14				14
15				15
16				16
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87				87
88				88
89				89
90	**Total**	(117,517)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,000)	0	0	(8,283)	0	0	0	0	0	0	0	(10,283)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,444)	0	5,110	0	0	0	0	0	0	0	0	3,666	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,444)	0	5,110	(8,283)	0	0	0	0	0	0	0	(6,617)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(312)	0	0	0	0	0	0	(312)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	(312)	0	0	0	0	0	0	(312)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(394,932)	0	0	0	0	(63)	0	0	0	(394,995)	19
20	Fees, Subscriptions & Promotions	(24,849)	0	323	0	0	0	0	0	0	0	0	(24,526)	20
21	Clerical & General Office Expenses	0	0	21,567	13,695	11,856	0	0	0	0	0	0	47,118	21
22	Employee Benefits & Payroll Taxes	0	0	36,264	0	(117)	0	0	0	0	0	0	36,147	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,320	0	0	0	0	0	0	0	0	8,320	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	88	0	0	0	0	0	0	0	0	88	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,849)	0	(328,370)	13,695	11,739	0	0	(63)	0	0	0	(327,848)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,293)	0	(323,260)	5,412	11,427	0	0	(63)	0	0	0	(334,777)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	15,315	0	0	0	0	0	0	0	0	15,315	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	2,973	0	0	0	0	2,973	31
32	Interest	(472)	0	2,916	0	0	0	4,920	0	0	0	0	7,364	32
33	Real Estate Taxes	0	0	3,607	0	0	0	0	0	0	0	0	3,607	33
34	Rent-Facility & Grounds	24,520	0	0	0	0	0	0	0	0	0	0	24,520	34
35	Rent-Equipment & Vehicles	0	0	11,406	0	0	0	0	0	0	0	0	11,406	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	24,048	0	33,244	0	0	0	7,893	0	0	0	0	65,185	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(138,865)	0	0	(20,126)	(42,398)	0	(127,587)	0	0	0	0	(328,976)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(138,865)	0	0	(20,126)	(42,398)	0	(127,587)	0	0	0	0	(328,976)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(143,110)	0	(290,016)	(14,714)	(30,971)	0	(119,694)	(63)	0	0	0	(598,568)	45

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc	100	see pg 6k…		see pg 6k…		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		see following pages…	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	maintenance/utilities	$	Alden Management Services, Inc.		$ 5,110	$ 5,110	15
16	V		19	professional fees	401,935	Alden Management Services, Inc.		7,003	(394,932)	16
17	V		20	licenses/fees		Alden Management Services, Inc.		323	323	17
18	V		21	gen'l & admin		Alden Management Services, Inc.		21,567	21,567	18
19	V		22	employee costs		Alden Management Services, Inc.		36,264	36,264	19
20	V		24	auto/seminar		Alden Management Services, Inc.		8,320	8,320	20
21	V		26	insurance		Alden Management Services, Inc.		88	88	21
22	V		30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V		32	interest		Alden Management Services, Inc.		2,916	2,916	23
24	V		33	real estate tax		Alden Management Services, Inc.		3,607	3,607	24
25	V		35	auto lease		Alden Management Services, Inc.		11,406	11,406	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 401,935			$ 111,919	$ * (290,016)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	tube feeding	$ 16,234	Pyramid Healthcare Services		$ 7,951	$ (8,283)	15
16	V		39	nursing supplies	5,558	Pyramid Healthcare Services		1,834	(3,724)	16
17	V		39	supplies / per diem fees	45,560	Pyramid Healthcare Services		29,158	(16,402)	17
18	V		21	gen'l & admin		Pyramid Healthcare Services		13,695	13,695	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 67,352			$ 52,638	$ * (14,714)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	drugs	$ 163,454	Forum Extended Care II		$ 123,037	$ (40,417)	15
16	V		10	house stock	1,261	Forum Extended Care II		949	(312)	16
17	V		39	iv	8,011	Forum Extended Care II		6,030	(1,981)	17
18	V		22	vaccinations	471	Forum Extended Care II		354	(117)	18
19	V		21	gen'l & admin		Forum Extended Care II		11,856	11,856	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 173,197			$ 142,226	$ * (30,971)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 425,132	COMMUNITY PHYSICAL THERAPY	100.00%	$ 297,545	$ (127,587)	15
16	V	31	AMORTIZATION				2,973	2,973	16
17	V	32	INTEREST				4,920	4,920	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 425,132			$ 305,438	$ * (119,694)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Construction management fees	$ 4,494	Alden Bennett Construction	0.00%	$ 4,431	$ (63)	15
16	V	19	architectural/design fees	270	Alden Design Group		270		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,764			$ 4,701	$ * (63)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President-AMS	CEO	100.00	188,111	1.3	3.26	SALARY	$ 6,335	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	72,063	1.3	3.26	SALARY	2,427	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten.	b.	72,621	1.3	3.26	SALARY	999	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,671	0.8	0.02	fees	180	10a-3	4
5											5
6											6
7											7
8											8
9	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										9
10	b. Terry is the son-in-law of Floyd Schlossberg.He was the administrator of Alden Valley Ridge for 7 months and in construction/misc. for 5 months in 2000.										10
11	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										11
12											12
13								TOTAL	$ 9,941		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ALDEN MANAGEMENT SERVICES, INC.
Street Address: 4200 W. PETERSON
City / State / Zip Code: CHICAGO, IL 60646
Phone Number: (773)286-3883
Fax Number: (773)286-3742

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE PAGE 8A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LINE OF CREDIT--AFFILAT	X		OPERATIONS	NONE					VARIES	48,146	6
7	RELATED PARTY	X		OPERATIONS	NONE					VARIES	2,916	7
8	RELATED PARTY-CPT	X		OPERATIONS	NONE					VARIES	4,920	8
9	TOTAL Facility Related						$	$			$ 55,982	9
	B. Non-Facility Related*											
10	INTEREST INCOME			OFFSET INTEREST EXPENSI	(GL 4301)						(11)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11)	14
15	TOTALS (line 9+line14)						$	$			$ 55,971	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	170,384	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	161,182	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,202)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	169,240	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	160,038	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	132,840	8
	1996	163,330	9
	1997	159,440	10
	1998	162,271	11
	1999	161,182	12

LINE4: 2000 ACCRUAL BASED ON 5% INCREASE OF PRIOR YEAR BILL: $161,182 X 1.05=169,241

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER HEADS			1995	1,832	73	25	73		385	9
10	ROOF REPAIRS			1995	2,000	200	10	200		1,033	10
11	INSTALLED ELECTRIC AMPS			1996	1,870	374	5	374		1,621	11
12	SIGNS			1996	1,800	180	10	180		795	12
13	WATER HEATER			1997	6,180	1,236	5	1,236		4,326	13
14	REPLACE PIPES			1997	5,949	1,190	5	1,190		3,768	14
15	EXHAUST FANS			1997	8,403	1,681	5	1,681		5,322	15
16	WASHING MACHINE MOTOR			1998	1,576	197	8	197		558	16
17	ABC (general construction)-major repairs/improvement			1999	5,713	571	10	571		857	17
18	ABC (general construction)-major repairs/improvement			1999	2,326	233	10	233		329	18
19	ABC (general construction)-major repairs/improvement			1999	2,092	209	10	209		296	19
20	ABC (general construction)-major repairs/improvement			1999	1,870	187	10	187		218	20
21	ABC (general construction)-major repairs/improvement			1999	12,658	1,266	10	1,266		1,477	21
22	ABC (general construction)-major repairs/improvement			1999	2,250	225	10	225		244	22
23	ABC (general construction)-major repairs/improvement			1999	10,225	1,022	10	1,022		1,108	23
24	CLIMATE SERVICE(exhaust fan)			1999	2,280	456	5	456		570	24
25	Supreme Sheet Metal(Install oxygen exhaust system)			2000	8,555	980	8	980		980	25
26	Hopkins ILL Elevator (Repair Elevator' s Door)			2000	1,518	152	5	152		152	26
27	D,B.S. Contracting(lawn spinkler)			2000	15,500	207	25	207		207	27
28	ABC (misc construction work)			2000	6,937	231	5	231		231	28
29	ABC-new hot water system			2000	49,596	2,067	20	2,067		2,067	29
30	ABC-metal studs/replace showers			2000	23,903	797	10	797		797	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 175,034	$ 13,733		$ 13,733	$	$ 27,340	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 154,090	$ 19,237	$ 19,237	$	varies	$ 65,222	37
38	Current Year Purchases	42,541	2,845	2,845		varies	2,845	38
39	Fully Depreciated Assets	20,651	1,214	1,214		varies	20,651	39
40								40
41	TOTALS	$ 217,282	$ 23,297	$ 23,297	$		$ 88,718	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 477,175	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 43,039	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 43,039	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 334,320	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	na	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TRUST NO. 43185 (T.L. ENTERPRISES, INC.,)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		96	3/1/95	$	15		3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 3/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ 711,312
13.	12/31/02	$ 723,284
14.	12/31/03	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 8,349 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ NA

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 161,539	$		$ 161,539	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,180			12,180	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			252,420			252,420	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A	# of prescrpts				115,656		115,656	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A					(76,646)		(76,646)	13
14	TOTAL			$		$ 426,139	$ 39,010		$ 465,149	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 117,918	$	1
2	Cash-Patient Deposits	10,516		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (36,543))	1,239,599		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,984		6
7	Other Prepaid Expenses	2,818		7
8	Accounts Receivable (owners or related parties)	1,758,456		8
9	Other(specify):	78,783		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,281,072	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	254,224		15
16	Equipment, at Historical Cost	147,194		16
17	Accumulated Depreciation (book methods)	(127,423)		17
18	Deferred Charges	64,696		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	288,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 626,690	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,907,763	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,814,643	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,387		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	133,014		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	169,241		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	378,558		35
	Other Current Liabilities(specify):			
36	third party			36
37	other accu. Exps	243,798		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,800,726	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,800,726	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,107,037	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,907,763	$	48

***(See instructions.)**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,060,903	1
2	Restatements (describe):		2
3	**external audit adjustments done after 1999 cost report filed**		3
4	**which have no effect on reimbursement costs: bad debt expenses,**		4
5	**medicare revenues**	(122,905)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 937,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	169,039	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 169,039	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,107,037	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,860,523	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,860,523	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	250,999	6
7	Oxygen	2,515	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 253,513	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,317	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	718	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,035	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Adj's made to prior year expenses. Since prior year reports**		28
28a	**were not used, we've made no offsetting adjs on pg 5 or 5a.**	15,273	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,273	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,132,355	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	850,048	31
32	Health Care	1,331,788	32
33	General Administration	986,205	33
	B. Capital Expense		
34	Ownership	948,446	34
	C. Ancillary Expense		
35	Special Cost Centers	794,125	35
36	Provider Participation Fee	52,704	36
	D. Other Expenses (specify):		
37	**Note: this will not agree to page 3 & 4 because related party**		37
38	**amounts are entered on page 3&4.**		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,963,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	169,039	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 169,039	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,713	2,805	$ 52,734	$ 18.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,164	21,111	446,964	21.17	3
4	Licensed Practical Nurses	6,288	6,598	106,418	16.13	4
5	Nurse Aides & Orderlies	57,290	60,933	523,118	8.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,088	5,428	73,100	13.47	9
10	Activity Assistants	3,570	3,720	30,133	8.10	10
11	Social Service Workers	2,032	2,116	34,785	16.44	11
12	Dietician	10,110	10,787	84,619	7.84	12
13	Food Service Supervisor	3,416	3,512	46,186	13.15	13
14	Head Cook	6,036	6,436	66,964	10.40	14
15	Cook Helpers/Assistants	116	116	1,508	13.00	15
16	Dishwashers					16
17	Maintenance Workers	2,320	2,664	47,414	17.80	17
18	Housekeepers	8,825	9,736	82,032	8.43	18
19	Laundry	6,171	6,530	63,601	9.74	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,968	2,138	30,257	14.15	22
23	Office Manager	6,365	6,699	72,918	10.88	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,909	4,444	63,694	14.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical Supp. Sup	1,228	1,284	24,643	19.19	33
34	TOTAL (lines 1 - 33)	147,609	157,057	$ 1,851,088 *	$ 11.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,060	11-3	44
45	Social Service Consultant	8	412	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	$ 2,472		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIA ARGAMSO	ADMINISTRATOR		$ 31,702
DIPAOLO CARRIE	ADMINISTRATOR		27,895
OLIVER UMADHAY	ADMINISTRATOR		16,281
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,878

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MANAGEMENT SVS.	MGMT. FEES	$ 401,935
BLACKMAN KALLICK	ACCOUNTING FEES	14,134
KEN F. / B. GREENBURG H.	LEGAL	22,577
VARIOUS PROFESSIONAL FEES	PRO. FEES	1,307
ALDEN DESIGN	DESIGN FEES	270
ALDEN BENNET CONSTRUCTIO	CONSTRUC. FEES	4,494
US GAS & ENERGY	UTILITY CONSULT	360
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 445,077

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,763
Unemployment Compensation Insurance	12,960
FICA Taxes	139,172
Employee Health Insurance	30,923
Employee Meals	24,723
Illinois Municipal Retirement Fund (IMRF)*	
Chicago head tax	3,976
DENTAL / LIFE INSURANCE	211
EMP. RELATIONS /EMP. VACC	2,614
PAYROLL MISC. COST / TUITION REIMB.	1,476
PENSION / 401K MATCH	15,646
UNION HEALTH & WELFARE INSURANCE	26,482
RELATED PARTY	36,147
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,093

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	(3,063)
Health Care Worker Background Check	
(Indicate # of checks performed)	
Misc. Subscriptions (IHCA and others)	4,314
City of Chicago License	1,000
Misc. Inspections	430
Related Party	323
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,004

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
AUTO & TRAVEL	281
In-State Travel	
Seminar Expense	
SEMINARS	1,118
RELATED PARTY	8,320
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,719

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Climate Services-Piping	9/95	$ 1,809	5	$ 362	$ 362	$ 362	$ 241	$ 0	$	$	$	$
2	Painting	9/95	2,478	3	826	551							
3	Painting	11/95	4,500	3	1,500	1,250							
4	Painting	12/95	1,497	3	499	457							
5	ONASSIS (PAINTING)	1/96	1,369	3	456	456							
6	Climate Service, Inc. (boil	1/96	2,015	15	134	134	134	134	134	134	134	134	134
7	ONASSIS (PAINTING)	2/96	1,541	3	514	514	43						
8	Great Lakes Plumbing (fix	3/96	1,739	20	87	87	87	87	87	87	87	87	87
9	ONASSIS (PAINTING)	3/96	1,360	3	453	453	76						
10	Superior Painting & Deco	3/96	3,400	3	1,133	1,133	189						
11	Superior Painting & Deco	5/96	1,626	3	542	542	181						
12	Superior Painting & Deco	6/96	1,534	3	511	511	213						
13	Superior Painting & Deco	7/96	1,566	3	522	522	261						
14	Superior Painting & Deco	7/96	1,671	3	557	557	279			continued on page 22A, includes grand total…			
15	Superior Painting & Deco	8/96	1,627	3	542	542	316						
16	Superior Painting & Deco	9/96	907	3	302	302	201						
17	Superior Painting & Deco	9/96	950	3	317	317	211						
18	BuildIng Plumbing & Hea	10/96	1,831	15	122	122	122	122	122	122	122	122	122
19	ONASSIS (PAINTING)	12/96	1,607	3	536	536	491						
20	TOTALS		$ 35,026		$ 9,916	$ 9,349	$ 3,166	$ 584	$ 343	$ 343	$ 343	$ 343	$ 343

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. **Illinois Healthcare Assoc. $4,314**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES** What was the average life used for new equipment added during this period? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,664** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO** If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **52,704** This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,723** Has any meal income been offset against related costs? **NONE** Indicate the amount. $ **N/A**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO** If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**

d. Have vehicle usage logs been maintained? **N/A**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES** Firm Name: **Blackman Kallick Bartelstein , LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvemen Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Climate Serv (repair boiler)	Feb-97	1,644	3	502	548	548	46	0				
2	Climate Serv (repair/insulate piping)	Apr-97	2,348	3	587	783	783	195	0				
3	Climate Serv(insulation-remove drywall on p	Jun-97	3,865	3	752	1,288	1,288	537	0				
4	Climate Serv(install circulating pump)	Sep-97	2,585	3	287	862	862	574	0				
5	Appliance(air conditioning for kitchen)	Aug-97	2,412	3	335	804	804	469	0				
6	Great L.P.(remove & install pump)	Dec-97	2,595	3	72	865	865	793	0				
7	Appliance C.(a/c for kitchen)	May-98	3,702	3		823	1,234	1,234	411	0			
8	CSI(install ductwork for dryer exhaust)	Sep-98	2,670	3		297	890	890	593	0			
9	Custom A.C. (carpeting)	Dec-98	2,940	3		82	980	980	898	0			
10	Custom A.C.(finance charge)	Dec-98	192	3		5	64	64	59	0			
11	painting>$1,500 ytd 1999	7/99	11,700	3			1,950	3,900	3,900	1,950	0		
12	ABC(repair floor and roof)	9/00	10,285	3				1,143	3,428	3,428	2,286	0	
13	ABC(misc. construction job)	11/00	8,927	3				496	2,975	2,976	2,480	0	
14	painting>$1,500 ytd 2000	Jul-00	6,413	3				1,069	2,138	2,138	1,069	0	
15													
16													
17													
18													
19	Totals from Page 22 . . .		35,026		9,916	9,349	3,166	584	343	343	343	343	343
20	GRAND TOTALS		97,303		12,451	15,705	13,433	12,973	14,746	10,835	6,177	343	343